VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

February 13, 2015

Ms. Morgan Bovat, Administrator
Brownway Residence
328 School Street
Enosburg Falls, VT 05450-5500

Dear Ms. Bovat:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 13, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0118	A. BUILDING: _____ B. WING _____	C 01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNWAY RESIDENCE	328 SCHOOL STREET ENOSBURG FALLS, VT 05450

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R100	Initial Comments: An unannounced onsite licensing survey and investigation into a facility self-reported incident were conducted by the Division of Licensing and Protection from 1/12 - 1/13/15. The following regulatory deficiencies were identified.	R100	Please see attached Plans of Correction.	
R128 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to ensure that each resident had signed physician orders for all medications and treatments for 7 of 11 residents (Residents #1, 2, 3, 4, 7, 8, and 9) and failed to ensure that medications were administered consistent with physician orders for 1 of 11 residents whose medications were reviewed. (Resident's #2) Findings include: 1. Per medical record review and confirmed by the facility nurse on 1/13/15, there were no signed physician orders for all of the medications that are administered to Resident's #1, 2, 3, 4, 7, 8, and 9. Per interview with the nurse, s/he stated that s/he considered the clinical summaries that were provided to residents at their office visits to be their physician medication orders. The nurse was not able to produce evidence of signed orders at the time of the survey and confirmed that there was no electronic or conventional signature on	R128		

R128 - R266 POCs accepted 2/11/15 KCampos RN/PMC

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R128	Continued From page 1	R128		

the clinical summaries for the above residents. The nurse also confirmed that not all medications were listed on each of the clinical summaries making it difficult to determine the current medications.

2. Per record review on 1/13/15, Resident #2 was diagnosed as an insulin dependent diabetic who is administered both long and short acting insulin (additionally, short acting insulin is administered per sliding scale based on blood sugar levels before meals). The physician orders state that Resident #2 is to be administered NovoLog 100 units/ml, 6 units subcutaneously [by injection] with meals three times per day and additionally is to receive NovoLog insulin per sliding scale based on his/her blood sugar readings (which are specified in the order).

Per review of the Medication Administration Record (MAR) for January 2015, there is no documentation that Resident #2 was administered his/her "scheduled" 6 units of NovoLog insulin with his/her meals on 1/3/15 at 1600; on 1/4/15 at 0800 and 1100; on 1/5 and 1/6/15 at 1600; and on 1/10 and 1/11/15 at 0800, 1100, and 1600. There was a strikeout line written through the NovoLog administration order for each of the 3 time frames and an unsigned note stating, "see new instructions."

On 1/13/15 at at 11:15 AM, Med Tech #1 stated that on 1/4/15, s/he thinks that s/he administered Resident #2 his/her NovoLog insulin and confirmed s/he did not enter the administration on the MAR for either the 0800 or 1100 dose. On 1/13/15 at 2:07 PM, Med Tech #2 who was working on 1/10 and 1/11/15, stated that s/he did not administer the scheduled NovoLog insulin on those days as the medication had a line through it

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R128	Continued From page 2 and s/he thought it had been discontinued. Both Med Techs confirmed that they did not call the facility nurse to question what the strike through line meant. On 1/13/15 at approximately 2 PM, the facility nurse confirmed the MAR entries as listed above and stated that s/he did not know how or why the scheduled NovoLog had been crossed off in the MAR and confirmed that there was no documentation to explain this. The nurse stated that all changes in medication are to go through him/her and s/he was not aware of the discrepancy in the MAR until it came to attention during the survey. 3. Per record review on 1/13/15, Resident #1 has diagnoses that include Insulin- dependent Diabetes, and on 11/14/14 was sent to the hospital with hyperglycemia after becoming dizzy and falling. The resident went to a skilled nursing facility for a rehabilitation stay after the hospital, and was then readmitted to the home on 12/22/14. Per record review, there were no signed admission orders present in the record. The nursing home had written discharge orders that were faxed to the home, however the medication list was not signed, and the home did not send out the new orders to the primary physician for review and a signature that they were approved. Per interview on 1/13/15 at 4:30 PM, the Registered Nurse confirmed that the discharge orders were not complete with signed physician orders in the resident record, and that they had not been sent to the resident's primary care physician for an approval signature for medications and treatments upon readmitting Resident #1. See also R162.	R128		

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R140 SS=D	V. RESIDENT CARE AND HOME SERVICES	R140		

5.8 Physician Services

5.8.d All physicians' orders obtained via telephone shall be countersigned by the physician/licensed practitioner within 15 days of the date the order was given.

This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed through staff interview, the home failed to ensure that all orders obtained via telephone were countersigned by the providing physician/practitioner in a timely manner for 1 of 11 residents whose medications were reviewed during the survey. (Residents #3). Findings include:

Per medical record review and confirmed by the facility nurse on 1/13/15 at 10:38 AM, signed telephone orders were not obtained for Resident #3 for a medication change that included: a dose increase in Zolpidem from 5 to 10 mg on 12/2/14. (Zolpidem is a medication used for insomnia).

Per 1/13/15 review, the facility policy labeled Physicians Telephone Orders, states "Brownway Residence nursing staff must send follow up facsimile to any practitioner that provides an order via telephone. The practitioner will be expected to return the signed order back within 15 days of the date the order was given." Per interview on 1/13/15 at approximately 10:30 AM, the facility nurse stated that s/he was not aware that a signed telephone order was needed for the medication change.

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R145	Continued From page 4	R145		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES	R145		

5.9.c (2)

Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being;

This REQUIREMENT is not met as evidenced by:
Based on record review and confirmed by the facility staff RN, care plans have not been developed for 2 of 6 residents in the survey sample identified as having individualized needs requiring specific care and services (Residents #1, #2). Findings include:

1. Per record review on 1/13/15, Resident #2 was diagnosed as an insulin dependent diabetic who is administered both long and short acting insulin (additionally, short acting insulin is administered per sliding scale based on blood sugar levels before meals). The resident has additional diagnoses related to diabetes that include polyneuropathy and diabetic retinopathy. On 1/13/15 at 4:41 PM, the facility nurse confirmed that the resident did not have a care plan developed for diabetes care management, monitoring and treatment.

2. Per record review on 1/13/15, Resident #1 is an insulin dependent diabetic and is prescribed both long and short acting insulin. Resident #1 was sent to the hospital on 11/14/14 with hyperglycemia and an evaluation for injury after a fall. The resident went from the hospital to a

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R145	Continued From page 5 skilled nursing facility, and was readmitted to the home on 12/22/14. Per review of the plan of care for this resident, there was no area developed to address the diagnosis of Diabetes, and the appropriated interventions associated with this medical condition. On 1/13/15 at 4:33 PM, the Registered Nurse confirmed that the resident did not have a care plan developed for diabetes to address goals and interventions necessary to monitor and treat the condition.	R145		
R162 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by. Based on record review and staff interview the facility failed to ensure that staff not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order in the resident's record for 7 of 11 residents whose medications were reviewed (Resident's #1, 2, 3, 4, 7, 8 & 9). Findings include: 1. Per medical record review and confirmed by the facility nurse on 1/13/15, there were no signed physician orders for all of the medications that the facility Med Techs administer (for residents #1, 2, 3, 4, 7, 8, 9). Per interview with the nurse, s/he stated that s/he considered the clinical	R162		

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R162	Continued From page 6	R162		

summaries that were provided to residents at their office visit to be their physician medication orders and was not able to produce evidence of signed orders at the time of the survey. The nurse confirmed that there was no electronic or conventional signature on the summaries for the above residents and confirmed that not all medications were listed on each of the clinical summaries making it difficult to determine the current medications.

2. Per record review on 1/13/15, Resident #1 has diagnoses that include Insulin- dependent Diabetes, and on 11/14/14 was sent to the hospital with hyperglycemia after becoming dizzy and falling.. The resident went to a skilled nursing facility for a rehabilitation stay after the hospital, and was then readmitted to the home on 12/22/14. Per record review, there were no signed admission orders present in the record. The nursing home had written discharge orders that were faxed to the home, however the medication list was not signed, and the home did not send out the new orders to the primary physician for review and a signature that they were approved. The resident received medication administration from Medication techs on a daily basis. Per interview on 1/13/15 at 4:30 PM, the Registered Nurse confirmed that the discharge orders were not complete with signed physician orders in the resident record, and that they had not been sent to the resident's primary care physician for an approval signature for medications and treatments upon readmitting Resident #1. The nurse also confirmed that unlicensed staff were administering the medications to Resident #1 with no signed physician orders on file.

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R172	Continued From page 7	R172		
R172 SS=E	V. RESIDENT CARE AND HOME SERVICES	R172		

5.10 Medication Management

5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility failed to ensure that medications were appropriately labeled in accordance with professional standards for 8 of 8 residents for whom the facility was administering insulin. (Resident's #1, 2, 10, 11, 12, 13, 14 and 15). Findings include:

Per observation of the D- wing and main office medication carts on 1/13/15, 15 of 16 Insulin pens (7 Lantus solostar, 7 NovoLog flex and 2 Levemir flextouch pens), which were used for 8 residents were not labeled with the date the pens were first opened for use. Of the one pen that was dated when opened, the date was not legible. Per the Lantus solostar manufacturer's package insert, once the pen is in use (opened), it should be discarded after 28 days; the NovoLog manufacturer's insert states "Throw away .... a used Flexpen after 28 days, even if there is insulin left in the cartridge or syringe." The Levemir manufacturer's insert states that "the total time allowed at room temperature is 42 days regardless of whether the product is in-use or not in-use."

Additionally, the insulin pens were not labeled

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R172	Continued From page 8 with resident's full first and last name for 15 of the 16 pens; and instead were labeled with the resident's first and last initial, first name or first name and last initial. Per 1/13/15 review, the facility policy labeled Medication Management- Medication Oversight, states that "All medications and chemicals used in the home are labeled in accordance with currently accepted professional standards of practice." The labeling as identified above was confirmed by a staff med tech and the facility nurse on the afternoon of 1/13/15.	R172		
R173 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel shall have access to the keys This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, medications stored in the D-wing medication refrigerator were not stored under proper temperature controls affecting 2 of the 2 residents whose medications were stored in the refrigerator (Resident #2 and #10). Findings include:	R173		

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R173	Continued From page 9	R173		

The temperature log for the D-wing medication storage refrigerator lists that the Medication Fridge temperatures should be "Between 36-46 degrees....If the temp is outside of the parameter listed, please make adjustments and record the follow up temperature." Per observation on 1/13/15 with Med Tech #1 and confirmed by the facility nurse, the temp log for the unit refrigerator had recorded Fahrenheit temperatures as follows: On 12-30-14: 30 degrees; 12/31/14: 34 degrees; No temperatures recorded for 1/1/15 or 1/2/15; 1/3/15: 28 degrees; 1/4/15 32 degrees; 1/5/15: 33 degrees; 1/6/15: 35 degrees; 1/7/15: 30 degrees; 1/8/15: 36 degrees; 1/9/15: 30 degrees; 1/10/15: 32 degrees; 1/11/15: 31 degrees; 1/12/15: 35 degrees and 1/13/15 39 degrees. There was one note on 1/7/14 that the temperature was "turned [up]" but no other entries to indicate that the temperature was adjusted for other dates when the temperature was recorded as out of range; there were no follow up temperatures recorded on the log sheet during these dates to indicate the temperatures were rechecked.

On 1/13/15, per observation and confirmed by the Med Tech #1, both Lantus solostar and NovoLog flex pens (types of insulin used to treat Diabetes) for Resident's #2 and #10 were stored in the D-wing refrigerator. The manufacturer insert for both types of insulin state that the insulin should be stored between 36-46 degrees (F) and they should not be frozen. The Novolog package insert states, "Do not freeze. Do not use NovoLog if it has been frozen." The Lantus package insert states, "If a disposable insulin pen has been frozen or overheated, throw it away."

On 1/13/15 at 3:12 PM, Med Tech #1 stated that s/he did not check to see if the insulin was frozen

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R173	Continued From page 10 on 12/30/14 when the refrigerator's temperature was recorded as 30 degrees. On 1/13/15 at approximately 3:30 PM, the facility nurse confirmed the temperature log's low readings and stated that s/he was not alerted to the low temperatures. On 1/13/15, the facility manager reported that the out of range temps were not reported and stated that the med techs would be expected to report out of range temperatures to the facility nurse.	R173		
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the home failed to ensure that residents were free from abuse for one resident sampled (Resident #4). Findings include: Per observation on 1/13/15 at 9:08 AM, Resident #6 called over from the dining room and stated that s/he wanted to "get something off [his/her] chest." S/he reported that [s/he] "was inappropriate" with another resident and now could only go into another resident's room if accompanied by a staff person. When asked what happened, Resident #6 stated that the incident is "being investigated" and that the facility manager "knows all about it." Resident #6 stated that s/he gave another resident a "simple kiss" that "led to more than a simple kiss" with	R224		

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R224	Continued From page 11	R224		

Resident #4. Resident #6 stated that s/he wanted to apologize to [Resident #4] and stated that Resident #4 had a "brain aneurysm and is not cognitively intact." "The kiss became a french kiss... had two french kisses." S/he "did not say stop." Resident #6 stated that it progressed to Resident #4 giving [Resident #6] a "blow job." Resident #6 stated that it "was inappropriate for me....I made my mistake, now I'll pay." "Never once did [s/he] ask me to stop. [S/he] was enjoying it"...I realized that I invaded [his/her] private space"... [s/he] did not complain."

Immediately following the conversation with Resident #6, the facility manager was approached and confirmed knowledge of the allegation and was in the process of contacting APS (Adult Protective Services) to make a report. The home immediately protected the alleged victim by not allowing the alleged perpetrator near them, and made it very clear to him/her not to talk to Resident #4. A report was called into APS as required, the State Police notified, and family and physician as well (inc. legal guardian). The home attempted to conduct an emergency discharge which was denied by DLP for not meeting all necessary criteria. The home manager then proceeded to create a schedule of 1:1 supervision of Resident #6 during the evening /night hours (someone sitting outside the resident's door) and during the day having 15 minute checks so they were aware of his whereabouts, and having a staff person assigned to do this. Resident #4 did not recall the incident due to cognitive disability with very poor memory, however Resident #6 did not deny the allegations and there was video camera footage of him/her entering Resident #4's room on 1/11/15, and a black hat belonging to Resident #6 was found in Resident #4's room.

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R266 SS=E	IX. PHYSICAL PLANT	R266		

9.1 Environment

9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview, the facility failed to provide a safe, sanitary and homelike environment. Findings include:

1. During the initial tour of the facility on 1/12/15 at 9:45 AM, the bathroom shared by three residents on B wing had a strong smell of urine, and there was fluid on the floor that appeared to be urine. The floor was sticky where it was not wet. The observation was confirmed by the manager of the home at 9:50 AM, who stated that the housekeeper was not working today, and that the bathroom was in need of cleaning. At 11:15 AM, the bathroom was observed once again and found to be in the same condition with a puddle on the floor and strong odor.

2. A bathroom on the A wing was also observed to have a strong urine odor during the same initial tour on 1/12/14 with the facility manager. On 1/13/15, a resident who shares the bathroom (but asked not to be named) reported that strong odors from the bathroom and hall area have been a problem for some time and that the bathroom odors enter his/her adjoining room making it unpleasant to be in the room. Per observation on both 1/12/15 and 1/13/15 with the manager, the bathroom had a strong urine odor. Additionally,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0118	A. BUILDING: _____ B. WING _____	C 01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNWAY RESIDENCE	328 SCHOOL STREET ENOSBURG FALLS, VT 05450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R266	Continued From page 13 the baseboard heater near the toilet was missing its endcap, exposing metal edges and giving the bathroom a non-homelike appearance. 3. On 1/13/15 at approximately 5:30 PM, the facility manager and nurse confirmed that the connection between 2 baseboard front panels (on the C-wing main hallway) were screwed in place with a diagonal metal patch that protruded into the walking area of the hall and could pose a safety issue for residents who used the handrail directly above the patch. 4. On 1/12/14 residents in the dining hall (who chose not to be identified) reported a concern about the facility's cleaning practices and reported that the light fixtures above the tables were dirty for some time. On 1/13/15 at approximately 5:30 PM, per observation and confirmed by the facility manager, the light fixtures were observed to have moderate to heavy amounts of black debris visible in the opaque fixtures that were situated above the dining room tables. The manager confirmed that the light fixtures were not on the housekeeper's cleaning schedule.	R266		

R128

5.5.c Each Residents medication, treatment, and dietary services shall be consistent with the physicians orders.

1. Action to correct the deficiency

1) The Health Services Director faxed consolidated orders on every Resident to their PCP with a request for MD signature.

Expected completion date: Completed (1/12/2015 – 1/15/2015)

2) The order was rewritten to avoid confusion and all med techs received education on their inability to write or mark the MAR.

Expected completion date: Completed (1/12/2015)

3) Signed orders were obtained at the scheduled post rehab visit with PCP on 1/15/2015 as PCP will not sign off on discharge orders until residents are seen face to face following any short term rehab stay.

Expected Completion date: Completed (1/15/2015)

2. Measures to assure that it does not recur

1) Consolidated orders will continue to be sent to all Office Visits – Office Visit form has been updated to include verbiage that the physician has reviewed and agrees with the attached medication list (see attachment A).

Expected completion date: Completed (1/14/2015)

2) Staff reminders have been posted on the cart and in the med room reminding them not to write in the MAR.

Expected completion date: Completed (1/14/2015)

3) Physician re-admission forms have been developed for residents returning from rehab (see attachment B).

Expected completion date: Completed (1/14/2015)

3. How corrective actions will be monitored

Going forward, on a quarterly basis, the Health Services Director is responsible for medication reviews to assure that all residents have signed consolidated orders.

Expected completed date: Ongoing

R140

5.8.d All physicians orders obtained via telephone shall be countersigned by the physician/licensed practitioner within 15 days of the date the order was given.

1. Action to correct the deficiency

Order was located in the residents' medical record (see attachment C)

Expected completion date: Completed (12/02/2014)

2. Measures to assure that it does not recur

Nursing will continue to utilize their process of obtaining orders from physician offices.

Expected completion date: Completed (12/02/2014)

3. How corrective actions will be monitored

Going forward, on a quarterly basis, the Health Services Director is responsible for medication reviews to assure that all residents have signed consolidated orders.

Expected completed date: Ongoing

R145

5.9.c Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment.

1. Action to correct the deficiency

Both plan of care, for Resident #1 and #2, which required interventions based on diabetic status were updated by the Health Services Director.

Expected completion date: Completed (1/14/2015)

2. Measures to assure that it does not recur

Plan of care template has been edited to include a separate dietary focus which is automatically triggered when new care plans are initiated.

Expected completion date: Completed (1/14/2015)

3. How corrective actions will be monitored

Care plan reviews will continue to occur quarterly by the Health Services Director.

Expected completed date: Ongoing

R162

5.10.c Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order...

1. Action to correct the deficiency

1) Consolidated orders were obtained to satisfy the regulation for signed physician orders.

Expected completion date: Completed (1/12/2015 – 1/15/2015)

2) Signed orders were obtained at the appointment with PCP on 1/15/2015.

Expected completion date: Completed (1/15/2015)

2. Measures to assure that it does not recur

1) Consolidated orders will continue to be sent to all Office Visits – Office Visit form has been updated to include verbiage that the physician has reviewed and agrees with the attached medication list (see attachment A).

Expected completion date: Completed (1/14/2015)

2) Physician re-admission forms have been developed for residents returning from rehab (see attachment B).

Expected completion date: Completed (1/14/2015)

3. How corrective actions will be monitored

Going forward, on a quarterly basis, the Health Services Director is responsible for medication reviews to assure that all residents have signed consolidated orders.

Expected completed date: Ongoing

R172

5.10.h All medicines and chemicals used in the home must be labeled in accordance with current accepted professional standards of practice.

1. Action to correct the deficiency

All insulin was properly labeled, per regulation, immediately.

Expected completion date: Completed (1/13/2015)

2. Measures to assure that it does not recur

To ensure proper labeling, pre-printed labels were created for each resident requiring insulin administration. The labels include first and last name and a spot for staff to place the date that the insulin was opened. The labels are stored on the side of the medication fridge for easy access when new insulin is opened.

Expected completion date: Completed (1/14/2015)

3. How corrective actions will be monitored

Nursing will audit the insulin storage fridge weekly to ensure proper labeling and fridge temperatures.

Expected completed date: Ongoing

R173

5.10.h All medicines and chemicals used in the home must be labeled in accordance with current accepted professional standards of practice.

1. Action to correct the deficiency

Medication refrigerator was replaced secondary to inability to regulate to the proper temperature.

Expected completion date: Completed (1/15/2015)

2. Measures to assure that it does not recur

Med techs have been instructed to communicate abnormal fridge temperatures to the nurse. Nursing will be responsible for adjusting abnormal fridge temperatures.

Expected completion date: Completed (1/14/2015)

3. How corrective actions will be monitored

Nursing will audit the insulin storage fridge weekly to ensure proper labeling and fridge temperatures.

Expected completed date: Ongoing

See next page for R224 Plan of correction.

R266

9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.

1. Action to correct the deficiency

1) All bathrooms were deep cleaned by a contracted service.

Expected completion date: Completed (1/26/2015)

2) As explained, during the facility tour, the bathroom floor was scheduled to be replaced secondary to continued strong smell of urine which was not rectified by cleaning of the bathroom. Bathroom floor was replaced as was the base board heater.

Expected completion date: Completed (1/15/2015)

3) Base board heater was fixed by facility handyman.

Expected completed date: Completed (1/13/2015)

4) Light fixtures were cleaned by a contracted cleaning service.

Expected completed date: Completed (1/15/2015)

2. Measures to assure that it does not recur

1) New housekeeping has been hired with a background in janitorial services. Stronger attention is being placed on deep cleaning of bathroom areas.

2) Bathroom floors, which are not ceramic tile, are all being replaced secondary to the linoleum holding in odors.

3) Baseboard heaters were added to maintenance schedule for monthly inspections.

4) Light fixtures were added to the housekeeping assignment for monthly cleaning.

3. How corrective actions will be monitored

Weekly housekeeping meetings will occur until areas of concern are stable and routinely found at a high standard.

Expected completed date: Ongoing

R224

6.12 Residents shall be free from mental, verbal or physical abuse, neglect and exploitation.

Action to correct the deficiency

Resident #6 was ultimately discharged from their residency at Brownway Residence, Inc.

Expected completion date: Completed (1/26/2015)

Measures to assure that it does not recur and how it will be monitored

The facility will coordinate education for all residents regarding resident to resident interactions. Residents not in attendance will receive written education which summarizes the education provided in the group setting. Nursing will provide ongoing support to residents, male or female, who express sexualized desires or the desire for intimate relationships.

Expected completion date: Ongoing